U.S. Department of Labor

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Issue Date: 22 October 2004

In the Matter of:

LIGE M. SCARBERRY
Claimant

Case No.: 2003 BLA 5468

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances: Mr. William L. Roberts, Attorney
For Claimant

Mr. Robert S. Wilson, Attorney
For the Director

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER
APPROVAL OF MODIFICATION REQUEST
AWARD OF BENEFITS

This matter involves a claim filed by Mr. Lige M. Scarberry for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Discussion

As I discussed extensively with the parties at the hearing, this case presents a unique procedural issue. While the case was before the Benefits Review Board in the summer of 2001 based on Mr. Scarberry's appeal of a denial of a third modification request relating to a 1988 claim for black lung disability benefits, counsel for the Claimant requested that the "present application" be withdrawn and expressed an intention to file a new claim. In response, the Benefits Review Board ("BRB" and "Board") dismissed Mr. Scarberry's appeal. However, neither the Board nor the District Director took action on Mr. Scarberry's withdrawal request. If

a withdrawal of the 1988 claim had been approved,[1] then all the documents relating to Mr. Scarberry's first claim (DX 1)[2] would no longer be in the record. After much discussion, the parties agreed with my determination that the case before me involved a December 2001 modification request to a prior denial by Administrative Law Judge Mollie Neal in July 2001of Mr. Scarberry's third modification request. Mr. Scarberry's claim submission on December 10, 2001 constitutes his fourth modification request relating to his original claim filed in 1988. Accordingly, I will adjudicate the December 10, 2001 application as a modification request, governed by the procedures set forth in 20 C.F.R. § 725.310.

Procedural Background

Initial Claim

Mr. Scarberry filed his application for black lung disability benefits on March 4, 1988. After the case was reviewed by a claims examiner, his claim for benefits was denied on June 14, 1988 for failure to show that his pneumoconiosis was caused at least in part by coal mine work and that he was totally disabled. Mr. Scarberry appealed and on September 15, 1988, the District Director forwarded the claim to the Office of Administrative Law Judges ("OALJ") for a hearing.

First Administrative Law Judge Decision

Administrative Law Judge Henry Sayrs conducted a hearing on April 25, 1989. On June 21, 1989, Judge Sayrs denied Mr. Scarberry's claim for failure to: a) establish that Mr. Scarberry's pneumoconiosis was caused at least in part by coal dust; and, b) prove that he was totally disabled. Judge Sayrs credited Mr. Scarberry with 5 years of coal mine employment and determined that Mr. Scarberry established the presence of pneumoconiosis through chest x-ray evidence. On July 7, 1989, Mr. Scarberry appealed Judge Sayrs' denial of his application for benefits to the Benefits Review Board.

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[1]Under 20 C.F.R. §§ 725.306 (a) (1) to (3), an adjudication officer (District Director or Administrative Law Judge[1]) may approve the withdrawal of a claim if: a) the claimant presents the reasons for the withdrawal in writing; b) withdrawal of the claim is in the claimant's best interests; and, c) the claimant has not received interim benefits under 20 C.F.R. § 725.522. If a withdrawal request is approved, "the claim will be considered not to have been filed." 20 C.F.R. § 725.306 (b). Notably absent in that regulatory language is any other limitation on the approval authority. However, in *Lester v. Peabody Coal Company*, 22 BLR 1-183 (2002), and *Clevenger v. Mary Helen Coal Company*, 22 BLR 1-193 (2002), the Benefits Review Board restricted the extent of withdrawal approval authority. In both *Lester*, 22 BLR at 1-191, and *Clevenger*, 22 BLR at 1-200, the BRB stated ". . .the provisions at Section 725.306 are applicable only up until such time as a decision on the merits issued by an adjudication officer becomes effective." Certainly, the 1995 Benefit Review Board's affirmation of the denial of benefits by Judge Bober and the Board's April 1999 affirmation of Judge Miller's denial of the second modification request preclude withdrawal of Mr. Scarberry's 1988 claim.

[2]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

First Benefits Review Board Remand

On April 30, 1990, the Board vacated Judge Sayrs' findings concerning the relationship of pneumoconiosis to coal mine employment and remanded the case to him for re-evaluation of the medical opinions.

Second Administrative Law Judge Decision

On December 19, 1990, the case was reassigned to another administrative law judge, Judge Marvin Bober. On May 6, 1991, Judge Bober denied Mr. Scarberry's claim for benefits for failure to establish total disability; however, he found that Mr. Scarberry proved that his pneumoconiosis was caused by coal mine employment. On May 20, 1991, Mr. Scarberry appealed Judge Bober's denial of his application for black lung benefits.

Second Benefits Review Board Remand

The BRB vacated Judge Bober's findings regarding the weight of the medical evidence and remanded the case for re-evaluation of the medical evidence on August 10, 1993.

Third Administrative Law Judge Decision

On October 4, 1994, Judge Bober again evaluated the medical evidence. He concluded that Mr. Scarberry did not establish that he was totally disabled, relying on the more probative medical opinion. On October 17, 1994, Mr. Scarberry appealed his denial to the BRB.

Benefits Review Board Decision

The Board affirmed Judge Bober's decision on June 29, 1995.

<u>First Modification Request</u>

On June 27, 1996, Mr. Scarberry submitted new medical evidence, which was treated as a request for modification. On August 9, 1996, the District Director denied the modification request since the new evidence did not establish that Mr. Scarberry was totally disabled. Mr. Scarberry appealed the adverse decision on August 27, 1996 and the District Director conducted an informal conference and then issued findings on February 4, 1997. The District Director found that Mr. Scarberry had already established the presence of pneumoconiosis and that the disease arose from his coal mine employment; however, benefits were denied because Mr. Scarberry was unable to prove total disability. Prior to receiving the District Director's final determination, Mr. Scarberry submitted additional medical evidence. On February 10, 1997, the District Director informed Mr. Scarberry that his recent medical submission would be considered another modification request. In response, Mr. Scarberry withdrew his just recently filed appeal of the District Director's adverse decision.

Second Modification Request

After evaluating the new medical information, on March 24, 1997, the District Director denied the modification request since the new evidence did not establish that Mr. Scarberry was totally disabled. Mr. Scarberry appealed the denial of benefits on April 18, 1997 and his case was forwarded to the OALJ on April 28, 1997 for a hearing.

Administrative Law Judge Decision

Administrative Law Judge Edward Miller conducted a hearing on October 9, 1997. On April 6, 1998, Judge Miller denied Mr. Scarberry's claim for failure to establish total disability and a change in condition. On April 23, 1998, Mr. Scarberry appealed this denial to the BRB.

Benefits Review Board Decision

On April 27, 1999, the Board affirmed Judge Miller's decision.

Third Modification Request

On July 20, 1999, Mr. Scarberry filed a petition for modification. The District Director denied Mr. Scarberry's request for modification because Mr. Scarberry did not establish that he was totally disabled. Mr. Scarberry appealed the adverse decision on March 20, 2000 and the District Director forwarded the case to the OALJ on May 10, 2000.

Administrative Law Judge Decision

Administrative Law Judge Mollie Neal conducted a hearing on October 20, 2000. On July 31, 2001, Judge Neal denied Mr. Scarberry's third request for modification. Judge Neal found that Mr. Scarberry had established six years of coal mine employment and a change in condition because Mr. Scarberry established that he was totally disabled based on pulmonary function tests. At the same time, after reviewing all of the evidence of record, Judge Neal held that the greater weight of the evidence established that Mr. Scarberry was not totally disabled. On August 13, 2001, Mr. Scarberry appealed the adverse decision to the BRB.

Benefits Review Board Dismissal of Appeal

On September 10, 2001, Mr. Scarberry informed the Board that he wished to withdraw his present application. As a result, the Board dismissed the appeal on September 24, 2001. (DX 1).

Fourth, and Present, Modification Request

On December 10, 2001, Mr. Scarberry submitted another claim form to the District Director which represented a fourth petition for modification (DX 2). On April 3, 2002, the District Director issued a notice indicating that Mr. Scarberry would not be entitled to benefits because he had not proven any condition of entitlement. The parties were provided an

opportunity to file additional evidence (DX 13). When no additional evidence was submitted, the District Director denied benefits on October 16, 2002, finding that Mr. Scarberry had not proven any of the conditions of entitlement (DX 15). Mr. Scarberry filed a timely appeal on November 15, 2002 (DX 17). The District Director forwarded the case to the OALJ on February 19, 2003 (DX 20).

Pursuant to a Notice of Hearing dated April 1, 2003 (ALJ 1), then revised on May 27, 2003 (ALJ 2), I conducted a hearing in Abingdon, Virginia on June 10, 2003 attended by Mr. Scarberry, Mr. Roberts and Mr. Wilson. My decision in the case is based on the hearing testimony and all the documents admitted into evidence, DX 1 to DX 22, CX 1, and CX 2.

ISSUES

1. Length of coal mine employment

2. Whether, in filing a petition for modification on December 10, 2001, Mr. Scarberry has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement upon which the denial of his most recent claim was based or a mistake in determination of fact occurred in Administrative Law Judge Mollie Neal's July 31, 2001 adjudication.

3. If Mr. Scarberry establishes a change in one of the applicable conditions of entitlement or a mistake in determination of fact, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: Mr. Scarberry was a coal miner with post-1969 coal mine employment and Mrs. Linda Scarberry is a dependent for the purpose of augmenting any benefits that may be payable (TR, page 20).

Preliminary Findings

Born on November 7, 1945, Mr. Scarberry married Mrs. Linda Scarberry on April 27, 1963 (DX 1 and DX 2). Mr. Scarberry worked at the face of the coal mines in various capacities, setting timbers, coupling cars, shoveling coal onto the joys and into the cars, and performing general labor. His work required him to lift 50 to 100 or more pounds every day. He stopped working at the coal mines because of the "brute labor" and its adverse effect on his breathing.

After leaving coal mining, Mr. Scarberry traveled to Michigan and worked in a gravel pit where he was exposed to rock dust. At Holly Sand and Gravel, in Holly, Michigan, Mr. Scarberry was a mechanic repairing equipment as necessary. Once, during a strike in the gravel pit, for about one calendar quarter in 1975, Mr. Scarberry retuned to coal mining at a strip mine

with Rural Mining.[3] In that last job as a coal miner, Mr. Scarberry serviced mining equipment as a mechanic. Due to nearby blasting at the strip mine, Mr. Scarberry was exposed to coal dust while working as a mechanic. Once the strike was resolved, Mr. Scarberry returned to the gravel pit and worked a total of ten years. He ended his employment at the gravel pit in 1977 when he suffered a back injury (DX 1, DX 2, DX 4, TR, pages 26 to 31).

Mr. Scarberry experiences breathing problems by having shortness of breath after climbing a few steps, walking 50 to 100 feet or talking too much. He has been treated for these problems by Dr. Modi, Dr. Sundaram and Dr. Patel. Dr. Modi treated him for three or four years and Dr. Sundaram has treated him for the past five years. He uses oxygen at night and takes breathing pills and inhalers to improve his breathing. Mr. Scarberry presently does not do anything during the day. He has never smoked cigarettes and does not know why Dr. Hussain indicated tobacco abuse (TR, pages 29 to 34).

Issue # 1 – Length of Coal Mine Employment

According to Mr. Scarberry, he was exposed to dust for 16 years. However, he also acknowledged at the hearing that he was only exposed to coal dust for a total of six years, when he worked in coal mines (TR, page 27). The remaining portion of his dust exposure occurred after he left coal mining, when he went to work in a gravel pit and was exposed to rock dust for another ten years. According to Mr. Scarberry, the gravel pit did not involve any coal mining (TR, page 29).

In his June 1989 decision concerning Mr. Scarberry's claim Judge Sayrs found that he had established 5 years of coal mine employment. Subsequently, the BRB did not disturb Judge Sayrs' finding of 5 years of coal mine employment. Next, in an April 1998 adjudication, Judge Miller found that Mr. Scarberry had established six years of coal mine employment. Most recently, before Judge Neal, the parties did not dispute Mr. Scarberry's stated length of coal mine employment of six years. As a result, Judge Neal found that Mr. Scarberry had worked in the coal mines for six years.

In the present modification request before me, while the parties appear to dispute the length of Mr. Scarberry's exposure to dust. Upon close examination, including the extensive employment with numerous coal companies from 1962 through 1966 documented in the Social Security earnings report (DX 5), and based on Mr. Scarberry's admission, I find the actual duration of his coal mine employment and related exposure to coal dust covered no more than six years. Since Mr. Scarberry's subsequent gravel pit work was not an integral part of coal mining,[4] his additional ten year exposure to rock dust in the gravel pit does not qualify as coal mine employment. As result, upon my review of the employment record and considering Mr.

[3]Mr. Scarberry testified: "I left the coal mine and went to Michigan. And went to a gravel pit then. Then, they were on strike and I came back to a strip mine, Rural Mining, and I worked one quarter out; I'm not sure just how long I worked but I know it was in '75." TR, page 30.

[4]*See* 20 C.F.R. §725.101 (a) (12) coal mining involves the extraction of coal from its natural deposits in the earth and the preparation of extracted coal.

Scarberry's hearing testimony, I concur with Judge Neal's determination that Mr. Scarberry has no more than six years of coal mine employment.

At this point, I need to address one other significant aspect about Mr. Scarberry's coal mine employment. In both documentary and testimonial work histories, until the hearing before me, Mr. Scarberry has represented that he last mined coal in November 1966 when he was working as a motor operator for Compton Coal Company. As result, Judge Sayrs, Judge Miller, and Judge Neal determined that Mr. Scarberry last mined coal in late 1966 when he was performing the heavy labor associated with operating a mining motor.

However, following submission of his most recent modification request, the District Director obtained a history of Mr. Scarberry's earnings from the Social Security Administration, DX 5. While that documentation verifies Mr. Scarberry's recollection about his coal mining in the 1960s, the report also shows that during July through September 1975, Mr. Scarberry earned $639 from the Rural Mining Company, headquartered in Louisville, Kentucky. As previously set out in the preliminary findings, at my hearing, Mr. Scarberry explained that during a strike at the Michigan gravel pit he returned to a strip coal mine for one calendar quarter in 1975 and worked as a mechanic on mining equipment. Accordingly, contrary to previous determinations, I find: a) Mr. Scarberry last worked as coal miner in September 1975; and, b) his last coal mine employment involved work as a mechanic.

Further, in regards to the physical labor associated with his last coal mining work, Mr. Scarberry has focused on the exceptionally heavy labor associated with his job as an underground coal miner operating a mining motor. Mr. Scarberry did not present any evidence about the degree of physical effort required for his mechanic's job at the strip mine in 1975. Due to that evidentiary void, I turn to Mr. Scarberry's December 2001 submission to the District Director in which he describes the physical labor requirements of his work as an equipment mechanic at the gravel pit. At best, his gravel pit mechanic job required moderate physical labor. Based on that description, I conclude that the reasonably similar work of repairing strip mining equipment would also require no more than moderate physical labor.

Issue # 2 - Modification

Any party to a proceeding may request modification at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. § 725.310 (a). Upon the showing of a "change in conditions" or a "mistake in a determination of fact" the terms of an award or the decision to deny benefits may be reconsidered. 20 C.F.R. § 725.310. An order issued at the conclusion of a modification proceeding may terminate, continue, reinstate, increase or decrease benefit payments or award benefits.

According to the courts and BRB, the phrase "change in conditions" refers to a change in a claimant's physical condition. See *General Dynamics Corp. v. Director, OWCP*, 673 F.2d 23 (1st Cir. 1982) and *Lukman v. Director, OWCP*, 11 B.L.R. 1-71 (1988) (*Lukman II*). Under the regulatory provisions, to determine whether a claimant demonstrates a change in conditions, an administrative law judge ("ALJ") must first conduct an independent assessment of all newly

submitted evidence. Then, the ALJ must consider this new evidence in conjunction with all evidence in the official U.S. Department of Labor record to determine if the weight of the evidence is sufficient to establish an element of entitlement which was previously adjudicated against the claimant. K*ingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993); *Kovac v. BCNR Mining Corp*., 14 B.L.R. 1-156 (1990), *aff'd. on reconsideration*, 16 B.L.R. 1-71 (1992).

The modification process has been further expanded by the United States Supreme Court and federal Courts of Appeals when they considered cases involving the mistake of fact factor listed in the regulations. In *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971), the United States Supreme Court indicated that an ALJ should review all evidence of record to determine if the original decision contained a mistake in a determination of fact. In considering a motion for modification, the ALJ is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *See also Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993); *Director, OWCP v. Drummond Coal Co. (Cornelius)*, 831 F.2d 240 (11th Cir. 1987).

My determination of whether either a change in condition has developed or a mistake of fact occurred involves the four entitlement elements that a claimant must prove by a preponderance of the evidence to receive benefits under the Act. First, the coal miner must establish the presence of pneumoconiosis.[5] Second, if a determination has been made that a coal miner has pneumoconiosis, it must be determined whether the coal miner's pneumoconiosis arose, at least in part, out of coal mine employment.[6] If a coal miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.[7] Otherwise, the claimant must provide competent evidence to establish the relationship between pneumoconiosis and coal mine employment.[8] Third, the coal miner must demonstrate total respiratory disability.[9] Fourth, the coal miner must prove the total disability is due to coal workers' pneumoconiosis.[10]

In her denial of Mr. Scarberry's third request for modification, Judge Neal determined that Mr. Scarberry could not establish entitlement to benefits because after establishing a change in condition, the evidentiary record as a whole did not establish that Mr. Scarberry was totally disabled. In light of those findings, I will first evaluate whether Mr. Scarberry is able to demonstrate a change of conditions through new evidence developed since the record closed

[5]20 C.F.R. §718.202.

[6]20 C.F.R. §718.203 (a).

[7]20 C.F.R. §718.203 (b).

[8]20 C.F.R. §718.203 (c).

[9]20 C.F.R. §718.204 (a).

[10]20 C.F.R. §718.204 (a).

before Judge Neal on October 20, 2000 by showing he is now totally disabled. Secondly, if necessary, I will consider the entire evidentiary record to determine whether a mistake of fact has occurred in the determination of the total disability issue.

Change in Condition

Under the change of conditions analysis, I must examine the medical evidence presented since Judge Neal closed the evidentiary record upon conclusion of the hearing on October 20, 2000 to determine whether Mr. Scarberry has become totally disabled based on a pulmonary impairment.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Scarberry has not presented evidence of cor pulmonale with right-sided congestive heart failure and the record contains no evidence of complicated pneumoconiosis. As a result, Mr. Scarberry must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV_1 pre[11] post[12]	FVC pre Post	MVV pre post	% FEV_1 / FVC pre post	Qualified[13] pre Post	Comments
DX 7	Feb. 13, 2002 Dr. Hussain	56 72″	2.44 2.39	4.75 4.35	56	51.4% 54.9%	No[14] No	Airway obstruction
CX 1	Jun. 17, 2002 Dr. Sundaram	56 72″	2.23	3.95	50.9	56.5%	Yes	Moderate airway obstruction

Only one of the three, nearly contemporaneous pulmonary function tests produced results that qualify as totally disabling under the regulations. As a result, Mr. Scarberry is not able to establish a total respiratory disability through pulmonary function tests.

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO^2 (rest) pCO^2 (exercise)	pO^2 (rest) pO^2 (exercise)	Qualified[15]	Comments
DX 9	Feb. 13, 2002 Dr. Hussain	35.3 32.0	67.0 52.0	No[16] Yes	Hypoxemia. Valid[17]

Under the provisions of 20 C.F.R. § 718.204 (b) (2) (ii), if the preponderance of the arterial blood gas studies qualify under Appendix C of Section 718, then in the absence of evidence to the contrary, the blood gas evidence shall establish a miner's total disability. Adjudication under this regulatory section requires a five step process.

First, an administrative law judge must determine whether the tests conform to the arterial blood gas study procedural requirements in 20 C.F.R. § 718.105. Second, the results are compared to the qualifying values for the various tests listed in Appendix C to determine

[11]Test result before administration of a bronchodilator.

[12]Test result following administration of a bronchodilator.

[13]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal or less than the value in Table B5, **or** the ratio FEV1/FVC has to be equal to or less than 55%.

[14]The qualifying FEV_1 number is 2.28 for age 56 and 72.0″; the corresponding qualifying FVC and MVV values are 2.89 and 91, respectively.

[15]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[16]For the pCO^2 of 35, the qualifying pO^2 is 65, or less and for the pCO^2 of 32, the qualifying pO^2 is 68, or less.

[17]Dr. Michos certified that the arterial blood gas study taken on February 13, 2002 is valid (DX 10).

whether the test qualifies. Third, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. Fourth, a determination must be made whether the preponderance of the conforming and valid arterial blood gas studies supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming tests establishes total disability, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is made to see if it outweighs the tests that support a finding of total respiratory disability. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19, 1-21 (1987).

With these guidelines in mind, I first observe that February 13, 2002 arterial blood gas study appears to conform to procedural requirements and its validity has been certified by a Department of Labor physician. No challenge to its validity has been presented.

Next, the result of the post-exercise arterial blood gas test produced qualifying results, which renders Mr. Scarberry totally disabled. The pre-exercise result was not similarly qualifying and thus at first glance the arterial blood gas studies seem to be even, with no preponderance either qualifying or non-qualifying. However, because I have determined Mr. Scarberry's last coal mine employment as a strip mine mechanic required moderate physical labor, I consider the post-exercise blood gas result more probative on whether Mr. Scarberry has the respiratory ability to return to his last job as a coal miner. Consequently, the preponderance of the more probative arterial blood gas studies supports a finding of total disability under the regulations. .

Finally, no probative contrary evidence has been presented to indicate Mr. Scarberry does not suffer a total respiratory impairment. Although Dr. Hussain concluded Mr. Scarberry only had a mild impairment and retained the capacity to return to coal mining, the physician did not reconcile this conclusion with his exercise arterial blood gas finding which showed Mr. Scarberry was totally disabled upon exercise. In the absence of any explanation by Dr. Hussain for the seeming disconnect between his medical test and conclusion on total disability, his opinion has diminished probative value concerning total disability and does not refute the objective medical determination of total disability established by the exercise arterial blood gas study. Consequently, I find Mr. Scarberry has proven through the preponderance of the more probative arterial blood gas study evidence developed since the close of the previous record in October 2000 that he is now totally disabled, which constitutes a change in conditions. Having established a change in condition, Mr. Scarberry has now demonstrated that a modification of his claim may be appropriate. As a result, I must determine based on the entire record developed since Mr. Scarberry filed his claim in 1988 whether he is entitled to benefits under the Act.

Issue #3 - Entitlement to Benefits

As previously discussed, to receive benefits under the Act, Mr. Scarberry must prove by the preponderance of the probative evidence that he has pneumoconiosis that arose out of his coal mine employment and that he is totally disabled due to coal workers' pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[18] The regulatory definitions include both clinical or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[19] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[20] As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[21] and medical opinion (§ 718.202 (a)(4)). Since the record does not contain evidence that Mr. Scarberry has complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. Mr. Scarberry also has not submitted a biopsy report and the record obviously does not contain an autopsy report. As a result, Mr. Scarberry will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis. In addition, under the guidance of *Compton*,[22] I must consider both the chest x-ray evidence and medical opinion together to determine whether Mr. Scarberry can establish pneumoconiosis.

Chest X-Rays

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
June 17, 2002	CX 1	(unreadable signature)	Positive for pneumoconiosis, profusion category 1/1,[23] type p opacities,[24]

[18]20 C.F.R. § 718.201 (a).

[19]20 C.F.R. §§ 718.201 (a)(1) and (2).

[20] 20 C.F.R. § 719 (b).

[21]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

[22] *See Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

[23]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two

(same)[25]	CX 1	Dr. Sundaram, B[26]	Positive for pneumoconiosis, profusion category 2/1, type p/t opacities
February 13, 2002	DX 11	Dr. Hussain, B[27]	Completely negative.
August 22, 2000	DX 1	Dr. Mathur, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type p/s opacities
June 10, 1999	DX 1	Dr. Navani, BCR, B	Completely negative
(same)	DX 1	Dr. Sundaram, B	Positive for pneumoconiosis, profusion category 1/2, type p/q opacities
(same)	DX 1	Dr. Reddy, BCR	Positive for pneumoconiosis, profusion category 1/0, type p/q opacities
January 12, 1998	DX 1	Dr. Rubenstein, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type q/t opacities
December 17, 1997	DX 1	Dr. Forehand, B	Negative for pneumoconiosis
(same)	DX 1	Dr. Gaziano, B	Positive for pneumoconiosis, profusion category 1/0, type t/s opacities
June 4, 1996	DX 1	Dr. Francke, BCR, B	Completely negative
(same)	DX 1	Dr. Reddy, BCR	Positive for pneumoconiosis, profusion category 1/2, type p/q opacities
March 20, 1989	DX 1	Dr. Penman	Positive for pneumoconiosis, profusion category 1/1, type p rounded opacities
January 23, 1989	DX 1	Dr. Fisher, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type p/s opacities

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digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102 (b), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

[24]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

[25]The date of the x-ray which Dr. Sundaram is interpreting is omitted, however because the x-ray is associated with the medical evaluation conducted on June 17, 2002 and the cover letter from counsel for Claimant indicates that Dr. Sundaram renders a reading of the x-ray on that date, I will treat the x-ray as being taken on June 17, 2002.

[26]The following designations apply: A – A reader; B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. An "A reader" has either submitted six of his chest x-ray interpretations to the Appalachian Laboratory for Occupational Safety and Health ("ALOSH") or taken an approved ALOSH x-ray classification course. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii). Note: I take judicial notice of Dr. Sundaram's status as a B reader, through reference to www.oalj.dol.gov/public/blalung/refrnc.

[27]I take judicial notice of Dr. Hussain's B reader status, through reference to www.oalj.dol.gov /public /blalung /refrnc.

(same)	DX 1	Dr. Clarke, A	Positive for pneumoconiosis, profusion category 1/2, type p rounded opacities, emphysema present
May 17, 1988	DX 1	Dr. Pitman, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities
(same)	DX 1	Dr. Patel, BCR	Positive for pneumoconiosis, profusion category 1/1, type s/p opacities

Discussion

Of the ten chest x-rays in the record, the physicians who reviewed seven either agreed or expressed the only viable opinion concerning the particular x-ray. Based on these unchallenged readings, the February 13, 2002 chest x-ray is negative for pneumoconiosis, and the six films from May 17, 1988, January 23, 1989, March 20, 1989, January 12, 1998, August 22, 2000, and June 17, 2002 chest x-rays are positive for the presence of pneumoconiosis.

The remaining three chest x-rays generated a dispute among the medical experts. In the June 4, 1996 chest x-ray, Dr. Francke, a dual qualified radiologist, did not believe the film established the presence of pneumoconiosis, whereas Dr. Reddy, a radiologist without B reader qualifications interpreted the x-ray to be positive for pneumoconiosis. Due to Dr. Francke's superior qualifications for interpreting chest x-rays, his interpretation is more probative. Therefore, I consider the June 4, 1996 x-ray to be negative for the presence of pneumoconiosis.

The December 17, 1997 chest x-ray produced a similar dispute. Dr. Gaziano, a B-reader, found the chest x-ray established the presence of pneumoconiosis in Mr. Scarberry's lungs. In contrast, Dr. Forehand, also a B-reader, believed the x-ray to be negative for the presence of pneumoconiosis. This time, since both of these physicians are equally well qualified, their medical opinion disagreement represents an evidentiary draw. Consequently, I am unable to ascertain whether this chest x-ray establishes the presence of pneumoconiosis.

The physicians who reviewed the June 10, 1999 x-ray disagreed about the presence of pneumoconiosis in Mr. Scarberry's lungs. Dr. Navani, a dual qualified radiologist, believed that the film did not establish the presence of pneumoconiosis; however, both Dr. Sundaram and Dr. Reddy opined to the contrary, finding the film to be positive for the presence of pneumoconiosis. Although the consensus opinion of Dr. Sundaram and Dr. Reddy represent a preponderance of the medical opinion evidence, Dr. Navani, in a manner similar to Dr. Francke discussed above, possessed the better credentials as a dual qualified radiologist. As a result, Dr. Navani's combined radiologist and B reader expertise enhances the probative value of his interpretation such that I find the June 10, 1999 chest x-ray is negative for pneumoconiosis.

In summary, in the radiographic studies accomplished between May 17, 1988 and June 17, 2002, six of the chest x-rays were positive for the presence of pneumoconiosis; three films were negative; and one study produced inconclusive results. In other words, the preponderance of the chest x-rays establishes the presence of pneumoconiosis and supports a finding of pneumoconiosis under the provisions of 20 C.F.R. § 718.202 (a) (1).

Compton Analysis

As previously discussed, the court in *Compton* has directed that I must also consider all the other evidence in the record to determine whether an ultimate finding of pneumoconiosis is warranted. This evidence consists principally of medical opinions, treatment notes, and related pulmonary studies. To help place the diverse medical opinions into perspective, I will first set out the pulmonary tests results. Then, I will review the assessments of the numerous doctors who have considered Mr. Scarberry's pulmonary condition.

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV_1 pre post**	**FVC pre Post**	**MVV pre post**	**% FEV_1 / FVC pre post**	**Qualified pre Post**	**Comments**
CX 1	June 17, 2002 Dr. Sundaram	56 72″	2.23	3.95	50.9	56.5%	Yes	Moderate airway obstruction
DX 7	Feb. 13, 2002 Dr. Hussain	56 72″	2.44 2.39	4.75 4.35	56	51.4% 54.9%	No[28] No	Airway obstruction
DX 1	Aug. 22, 2000 Dr. Sundaram	54 72″	1.88	3.61	44	52%	Yes[29]	Moderate obstruction. Invalid per Dr. Michos
DX 1	June 10, 1999 Dr. Sundaram	53 72″	2.32	4.02	54	57.7%	Yes[30]	
DX 1	Jan. 12, 1998 Dr. Fritzhand	52 70″	2.4	4.5	68.4	53.3%	No[31]	Moderately severe COPD
DX 1	Dec. 17, 1997 Dr. Forehand	52 70″	2.71	4.8	53	56%	No	Normal
DX 1	Jan. 21, 1997 Dr. Modi	51 72″	1.85 1.89	3.72 4.09	47 55.5	49.7% 46.2%	Yes[32] Yes	Moderate obstruction. Invalid per Dr. Michos & Dr. Forehand

[28]The qualifying FEV_1 number is 2.28 for age 56 and 72.0″; the corresponding qualifying FVC and MVV values are 2.89 and 91, respectively.

[29]The qualifying FEV_1 number is 2.31 for age 54 and 72.0″; the corresponding qualifying FVC and MVV values are 2.92 and 93, respectively.

[30]The qualifying FEV_1 number is 2.33 for age 53 and 72.0″; the corresponding qualifying FVC and MVV values are 2.94 and 93, respectively.

[31]The qualifying FEV_1 number is 2.19 for age 52 and 70.1″; the corresponding qualifying FVC and MVV values are 2.76 and 88, respectively.

[32]The qualifying FEV_1 number is 2.36 for age 51 and 72.0″; the corresponding qualifying FVC and MVV values are 2.97 and 94, respectively.

DX 1	June 4, 1996 Dr. Sundaram	50 72″	2.96	4.93	64.5	60%	No[33]	Mild obstruction
DX 1	March 20, 1989 Dr. Penman	43 74″	2.84	4.06	57	70%	No[34]	Restrictive lung volume
DX 1	Jan. 23, 1989 Dr. Clarke	43 72″	1.8	4.4	27.2	41%	Yes[35]	Severe COPD. Invalid per Dr. Forehand
DX 1	May 17, 1988 Dr. Baxter[36]	42 72″	4.33	5.36	94	81%	No[37]	

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest) pO^2 (exercise)**	**Qualified**	**Comments**
DX 9	Feb. 13, 2002 Dr. Hussain	35.3 32.0	67.0 52.0	No[38] Yes	Hypoxemia. Valid[39]
DX 1	Jan. 12, 1998 Dr. Fritzhand	37.7	83.4	No[40]	
DX 1	Dec. 17, 1997 Dr. Forehand	34 34	63 82	Yes[41] No	Resting hypoxemia, corrects with exercise
DX 1	Jan. 21, 1997 Dr. Modi	37.8	63.4	No	
DX 1	March 20, 1989 Dr. Penman	36.3	78.3	No[42]	Hypoxia

[33]The qualifying FEV_1 number is 2.38 for age 50 and 72.0″; the corresponding qualifying FVC and MVV values are 2.99 and 95, respectively.

[34]The qualifying FEV_1 number is 2.65 for age 43 and 74.0″; the corresponding qualifying FVC and MVV values are 3.31 and 106, respectively.

[35]The qualifying FEV_1 number is 2.49 for age 43 and 72.0″; the corresponding qualifying FVC and MVV values are 3.11 and 100, respectively.

[36]The test does not list a physician's name but it was taken in conjunction with Dr. Baxter's pulmonary evaluation of Mr. Scarberry taken on May 17, 1988.

[37]The qualifying FEV1 number is 2.49 for age 42 and 72.0″; the corresponding qualifying FVC and MVV values are 3.13 and 99, respectively.

[38]For the pCO^2 of 35, the qualifying pO^2 is 65, or less and for the pCO^2 of 32, the qualifying pO^2 is 68, or less.

[39]Dr. Michos certified that the arterial blood gas study taken on February 13, 2002 is valid (DX 10).

[40]For the pCO^2 of 37, the qualifying pO^2 is 63, or less.

[41]For the pCO^2 of 34, the qualifying pO^2 is 66, or less.

[42] For the pCO^2 of 36, the qualifying pO^2 is 64, or less.

DX 1	May 17, 1988 Dr. Baxter	36	88.9	No	

Dr. Imtiaz Hussain
DX 8 and DX 13

On February 13, 2002, Dr. Hussain, board-certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation of Mr. Scarberry who complained of sputum, wheezing, dyspnea, and cough. Mr. Scarberry had a coal mine employment history of 6 years and stated he never smoked cigarettes. Upon examination of the chest, Dr. Hussain heard rhonchi. The chest x-ray was negative for pneumoconiosis. The pulmonary function test revealed an airways obstruction and the exercise arterial blood gas study showed hypoxemia. Based on his evaluation, Dr. Hussain diagnosed COPD (chronic obstructive lung disease). The physician did not believe Mr. Scarberry had an occupational lung disease related to his coal mine employment; instead, he questioned whether the COPD might be due to "tobacco abuse." Mr. Scarberry had a mild respiratory impairment related to COPD. However, he was not totally disabled and retained the capacity to work as a coal miner or engage in similar work.

Dr. Raghu R. Sundaram
DX 1, DX 17, CX 1, and CX 2

On June 4, 1996, Dr. Sundaram, board certified in internal medicine,[43] completed a pulmonary evaluation of Mr. Scarberry. Mr. Scarberry reported six years of coal mine employment and ten years in construction work; he was a non-smoker. His presenting complaint was shortness of breath upon exertion. Upon examination, Dr. Sundaram heard rhonchi and wheezes. A chest x-ray was positive for pneumoconiosis. The pulmonary function test showed a mild obstruction. Dr. Sundaram diagnosed coal workers' pneumoconiosis and silicosis due to prolonged exposure to "coal/mixed" dust. The physician opined that Mr. Scarberry could not return to coal mine employment or similar manual labor because he experiences shortness of breath with limited activity.

On November 25, 1996, Dr. Sundaram reported that Mr. Scarberry has never smoked and worked in the coal mines for 6 years and then construction work for 10 years. The physician believes that Mr. Scarberry is disabled and unable to return to active work. He interpreted an x-ray taken of Mr. Scarberry's chest in June 1996 to be positive for the presence of pneumoconiosis. Based on Mr. Scarberry's complaints of shortness of breath with limited activity, Dr. Sundaram believes the pneumoconiosis caused his disabling respiratory condition.

On June 6, 1997, Dr. Sundaram treated Mr. Scarberry for shortness of breath with limited activity. Dr. Sundaram opined that despite the results of Mr. Scarberry's pulmonary function test, which did not produce qualifying results, he is nonetheless totally disabled because he could not do coal mine work on a sustained basis. The physician further noted that because the pulmonary function test only tested Mr. Scarberry's lung function at rest, it did not represent an

[43]As I informed the parties at the hearing (TR, page 6), I take judicial notice of Dr Sundaram's board certification and have attached the certification documentation.

accurate measure of his ability to do coal work. He cannot work more than a six to eight hour period.

On June 10, 1999, Dr. Sundaram again examined Mr. Scarberry and reached the same conclusions. Mr. Scarberry's employment history included sixteen years of exposure to coal dust, six of those years in underground coal mines and ten years in the gravel pit. Mr. Scarberry complained of shortness of breath after walking on level ground or up a few steps. On physical examination, the physician heard rhonchi and wheezes. Chest x-rays were positive for pneumoconiosis and the pulmonary function test showed a problem with his lung volumes. Dr. Sundaram diagnosed coal workers' pneumoconiosis/silicosis due to prolonged exposure to coal dust and mixed dust. Due to his shortness of breath with limited activity, Mr. Scarberry was totally disabled from coal mine employment.

On October 16, 1999, Dr. Sundaram again evaluated Mr. Scarberry, who never smoked cigarettes. The chest x-ray was positive for pneumoconiosis; rhonchi and wheezes were heard on physical examination. Dr. Sundaram again diagnosed coal workers' pneumoconiosis due to prolonged exposure to coal dust and silica. Mr. Scarberry suffered a moderate pulmonary impairment and did not retain the respiratory capacity to perform the work of a coal miner due to shortness of breath with limited activity.

On August 23, 2000, Dr. Sundaram accomplished another pulmonary examination. Mr. Scarberry was a non-smoker with a sixteen year exposure to coal dust and silica. Rhonchi and wheezes were again present; the chest x-ray was positive for coal workers' pneumoconiosis; and, the pulmonary function test indicated the presence of a moderate airways obstruction. Dr. Sundaram diagnosed coal workers' pneumoconiosis due to a prolonged exposure to coal dust. Mr. Scarberry had a moderate impairment due to coal workers' pneumoconiosis, as demonstrated by his shortness of breath upon exertion, which precluded his return to coal mining.

On June 17, 2002, Dr. Sundaram evaluated Mr. Scarberry's pulmonary condition. Mr. Scarberry presented with a productive cough, wheezing and chest pain. He was a non-smoker who experienced 16 years of exposure to coal dust and silica. Upon examination, Dr. Sundaram heard rhonchi and wheezing. The chest x-ray was positive for pneumoconiosis and the pulmonary function test indicated a moderate airway obstruction. Dr. Sundaram diagnosed coal workers' pneumoconiosis. Mr. Scarberry was totally disabled due to his coal workers' pneumoconiosis. Dr. Sundaram also opined that Mr. Scarberry cannot work as a miner because of the shortness of breath that he experiences.

In an October 2002 questionnaire, Dr. Sundaram indicated he had treated Mr. Scarberry since July 1998. In his opinion, Mr. Scarberry had an occupational disease related to his six years of coal dust exposure. He had both clinical and legal pneumoconiosis. Coal dust exposure played a significant role in both types of pneumoconiosis. Based on the physical examination, pulmonary function test and chest x-ray, Dr. Sundaram concluded Mr. Scarberry was totally disabled and no longer retained the pulmonary capacity to work as a coal miner.

Dr. Vinod D. Modi
DX 1

About 1988,[44] Dr. Modi conducted a physical examination of Mr. Scarberry who was a non-smoker and last worked in a sand and gravel pit. Dr. Modi noted rales and rhonchi upon evaluation of the chest. The physician diagnosed Mr. Scarberry with COPD and recommended that Mr. Scarberry not be exposed to further dust or fumes. In addition, he suggested Mr. Scarberry refrain from bending, crawling, lifting, pushing or pulling.

On January 21, 1997, Dr. Modi reported that Mr. Scarberry had six years of coal mine employment and ten years in construction. A June 1996 chest x-ray was positive for coal workers' pneumoconiosis and a recent exercise blood gas study showed hypoxia, which qualified for total disability. In Dr. Modi's opinion, Mr. Scarberry was totally and permanently disabled from coal mining.

On September 27, 1997, Dr. Modi evaluated Mr. Scarberry's pulmonary condition. He reported that Mr. Scarberry never smoked. Mr. Scarberry was experiencing shortness of breath with little exertion and an arterial blood gas study show marked hypoxia. Therefore, Dr. Modi recommended that Mr. Scarberry not be exposed to further dust, fumes or gases and refrain from bending, crawling, lifting, pushing or pulling. He believed Mr. Scarberry to be totally disabled.

On January 25, 2000, Dr. Modi again commented on Mr. Scarberry's pulmonary condition. According to Dr. Modi, Mr. Scarberry worked in coal mines for six years and around mines for fourteen years. He suffered chronic shortness of breath and his chest x-rays showed the presence of pneumoconiosis. Dr. Modi concluded Mr. Scarberry had significant exposure to coal dust and was "quite symptomatic of this exposure." He recommended that Mr. Scarberry not be exposed to further coal dust or other fumes or gases.

Dr. Martin Fritzhand
DX 1

On January 12, 1998, Dr. Fritzhand evaluated Mr. Scarberry's pulmonary condition. Mr. Scarberry complained of long-term shortness of breath with increasing severity the past five years. His employment history included six years of coal mining. He had never smoked cigarettes. Mr. Scarberry was taking medication to improve his breathing. Upon physical exam, Dr. Fritzhand found Mr. Scarberry's chest to be normal. However, Mr. Scarberry had a radiographic history showing the presence of pneumoconiosis. A recent pulmonary function study showed a moderately severe pulmonary impairment. Based on the chest x-rays and Mr. Scarberry's employment history, Dr. Fritzhand diagnosed coal workers' pneumoconiosis. Even though Mr. Scarberry was a non-smoker, the pulmonary function test was abnormal and demonstrated that his respiratory function was impaired. Mr. Scarberry was permanently and totally disabled from coal mine work.

[44]Although the evaluation is undated, Dr. Modi lists Mr. Scarberry's age as 43. Mr. Scarberry was born in 1945.

Dr. John R. Forehand
DX 1

On December 17, 1997, Dr. Forehand, board-certified in pediatrics and allergy and immunology, conducted a pulmonary evaluation of Mr. Scarberry. Mr. Scarberry presented with a productive cough and dyspnea. He was a non-smoker and had worked six years as a coal miner. The chest x-ray was negative for the presence of pneumoconiosis. Both the physical exam of the chest and pulmonary function tests were normal. Although Mr. Scarberry had hypoxemia at rest, the arterial blood gas study showed improvement in the blood oxygen levels with exercise. Dr. Forehand concluded Mr. Scarberry did not have pneumoconiosis and was not significantly impaired. Mr. Scarberry's low oxygen level in resting arterial blood gas study simply reflected physical de-conditioning due to a sedentary lifestyle.

Dr. Forehand also reviewed Mr. Scarberry's medical record, including numerous chest x-ray interpretations, pulmonary function tests and arterial blood gas studies. In his opinion, while radiographic evidence of coal workers' pneumoconiosis existed, Mr. Scarberry did not have a totally disabling pulmonary impairment. Dr. Forehand noted that most of the pulmonary function tests did not meet the total disability standard. The two studies by Dr. Clarke and Dr. Modi, which showed an obstructive impairment were invalid due to excessive variability. Consequently, Dr. Forehand concluded Mr. Scarberry retained the pulmonary capacity to return to coal mining.

Dr. Samuel V. Spagnolo
DX 1

Dr. Spagnolo, board certified in pulmonary disease and internal medicine, reviewed some of the medical record evidence in Mr. Scarberry's case on March 28, 1989. He did not believe Mr. Scarberry was totally disabled based on pulmonary function and arterial blood gas tests, opining that he could return to his previous coal mine employment. Dr. Spagnolo was also "reluctant to make a diagnosis of pneumoconiosis based on a single x-ray" and only six years of exposure to coal dust.

Dr. Robert W. Penman
DX 1

On March 20, 1989, Dr. Penman evaluated Mr. Scarberry's pulmonary condition. The physician reported Mr. Scarberry had six years of coal mine employment, four years in underground mines and two years on the tipple, followed by twelve years of employment in a gravel pit. Mr. Scarberry never smoked. He complained of shortness of breath for the previous five years and also had problems with wheezing and a productive cough. A chest exam produced normal breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary study showed a restrictive impairment and the blood gas study indicated hypoxia. Dr. Penman concluded Mr. Scarberry had an occupational lung disease due to his coal mine employment. The physician diagnosed pneumoconiosis and lung impairment based on chest x-rays and lung function tests. Dr. Penman did not believe that Mr. Scarberry could return to his

previous coal mine employment or other similar employment. He attributed Mr. Scarberry's respiratory impairment to pneumoconiosis and silicosis.

Dr. W. F. Clarke
DX 1

On January 23, 1989, Dr. Clarke evaluated Mr. Scarberry's pulmonary condition. Mr. Scarberry presented with shortness of breath on exertion and at night. He also complained of a productive cough and indicated that he slept on two pillows at night. Mr. Scarberry worked in the coal mines for six years, four of those years inside the mines and two years outside the mines, before working another ten years in a gravel pit. Mr. Scarberry never smoked and he reported no history of tuberculosis. A chest exam showed the presence of rales and rhonchi. The chest x-ray was positive for pneumoconiosis and emphysema. The pulmonary function test revealed both a mild restrictive pulmonary disease and a severe chronic obstructive airways disease. Based on the chest x-ray and pulmonary function test, Dr. Clarke diagnosed coal workers' pneumoconiosis. He opined Mr. Scarberry was totally disabled due to pneumoconiosis, in part because he found no other significant etiology for the disease. According to Dr. Clarke, Mr. Scarberry cannot return to coal mine employment because of his coal workers' pneumoconiosis and associated ventilatory impairment.

On March 10, 1989, Dr. Clarke reviewed the medical evidence in Mr. Scarberry's file. He found sufficient evidence to diagnose coal workers' pneumoconiosis. He attributed the disease to Mr. Scarberry's total work history in coal mining and gravel pits for 17 years, causing "anthrosilicosis." Although Mr. Scarberry only worked six years in coal mining, Dr. Clarke highlighted a West Virginia medical study indicating that two to three years exposure may be sufficient for the development of pneumoconiosis in susceptible individuals. The physician found Mr. Scarberry to be totally disabled and unable to perform regular coal mine work. Additionally, he recommended that Mr. Scarberry refrain from further exposure to dust, noxious gas and free silicone dioxide.

Dr. Robert F. Baxter
DX 1

On May 17, 1988, Dr. Baxter evaluated Mr. Scarberry's pulmonary condition. Mr. Scarberry presented with shortness of breath and a five year history of coal mining and ten years in rock mining. He never smoked cigarettes. The physical exam of the chest revealed bilateral coarse rhonchi and hyper-resonance. The chest x-ray was positive for pneumoconiosis. Both the pulmonary function test and the arterial blood gas study were within normal limits. In light of the examination and chest x-ray, Dr. Baxter diagnosed COPD consistent with coal workers pneumoconiosis. In terms of etiology, Dr. Baxter cited coal dust exposure from 1960 through 1966 and rock dust from 1967 to 1978. At the same time, in light of the normal pulmonary studies, Mr. Scarberry was not totally disabled.

Discussion

Between 1988 and 2002, nine physicians considered whether Mr. Scarberry had pneumoconiosis. Relying principally on radiographic evidence, examinations, and at times, pulmonary tests, six doctors, Dr. Baxter, Dr. Clarke, Dr. Penman, Dr. Fritzhand, Dr. Modi,[45] and Dr. Sundaram, concluded Mr. Scarberry had pneumoconiosis. Initially, based on a negative chest x-ray, Dr. Forehand disagreed with this noted consensus of medical opinion. However, upon review of the medical record and multiple chest x-ray findings of pneumoconiosis, Dr. Forehand conceded Mr. Scarberry may have pneumoconiosis. Dr. Spagnolo was less certain and declined to render any diagnosis concerning pneumoconiosis based on one chest x-ray and only six years of coal mine employment. On the other hand, in contrast to every other physician, based on a negative chest x-ray interpretation, Dr. Hussain definitively concluded Mr. Scarberry did not have pneumoconiosis.

Due to this conflict of medical opinion, I must assess the probative value of the opinions, relying on the medical opinion that is both better documented and better reasoned. A physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. *See Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998) and 20 C.F.R. §718.140 (d).

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

Dr. Spagnolo's hesitation to diagnosis pneumoconiosis based on one chest x-ray interpretation and a short history of coal mine employment may carry an implicit finding that Mr. Scarberry does not have pneumoconiosis. However, such an implicit conclusion is equivocal. Additionally, since the chest x-ray interpretation Dr. Spagnolo reviewed was positive for

[45]Dr. Modi found both legal pneumoconiosis (coal dust related COPD) and clinical pneumoconiosis (in the form of a positive chest x-ray). Previously, due to a fraud conviction in the late 1980s, his medical opinion has been given no probative weight. In particular, on August 10, 1993, the Benefits Review Board affirmed Judge Bober's May 6, 1991 determination that Dr. Modi's conviction for defrauding the U.S. Department of Labor adversely affected the credibility of his medical opinion in this case. Likewise, the BRB also affirmed similar determinations by Judge Miller and Judge Neal (s*ee also Boyd v. Clinchfield Coal Co*., 46 F.3d 1122 (4th Cir. 1995)). At this point, I defer a decision on the probative value of his assessment since it is not determinative on this particular issue.

pneumoconiosis, his hesitation to concur with that assessment seems less than reasonable. Accordingly, Dr. Spagnolo's opinion has little probative value on the issue of pneumoconiosis.

Similarly, the equivocal nature of Dr. Forehand's less than forceful concession about the presence of pneumoconiosis also has diminished probative value.

Since the opinions of Dr. Spagnolo and Dr. Forehand have diminished probative value, the dispute concerning pneumoconiosis pits Dr. Hussain against six other doctors. Clearly, Dr. Hussain's negative determination is outweighed by the consensus among the six other doctors. At the same time, Dr. Hussain was only one of the two board certified pulmonologists to evaluate Mr. Scarberry.[46] With this particular expertise, Dr. Hussain was in a unique position to render a more probative medical opinion about the presence of pneumoconiosis in relation to the other physicians. However, for three reasons, I conclude his assessment has diminished probative value.

First, and most significant, Dr. Hussain concluded Mr. Scarberry did not have pneumoconiosis because he did not see evidence of pneumoconiosis in the chest x-ray he evaluated. Since I have concluded the preponderance of the chest x-ray evidence is actually positive for pneumoconiosis, Dr. Hussain based his assessment on documentation inconsistent with the preponderance of the evidentiary record.

Second, and closely related, Dr. Hussain only reviewed one chest x-ray. While several of the less qualified physicians reviewed the extensive radiographic record, Dr. Hussain just focused on his chest x-ray interpretation and was not aware that numerous positive chest x-rays interpretations existed in the record. Notably, Dr. Sundaram, Mr. Scarberry's treating physician, relied on several positive chest x-rays to support his finding of pneumoconiosis.

Third, after Dr. Hussain eliminated clinical pneumoconiosis as a diagnosis due to the absence of a positive chest x-ray, he failed to consider whether Mr. Scarberry may nevertheless have legal pneumoconiosis. Rather than address whether Mr. Scarberry's coal dust exposure might have contributed to his COPD, Dr. Hussain suggested tobacco abuse as a possible etiology for the obstructive impairment, even though nothing in the record even suggests Mr. Scarberry smoked cigarettes. In contrast, Dr. Sundaram did consider the presence of legal pneumoconiosis and indicated in his most recent assessment that Mr. Scarberry's obstructive breathing impairment was caused in part by his exposure to coal dust.

In summary, due to several deficiencies, Dr. Hussain's special status as a pulmonary disease expert does not overcome the preponderance of the other medical opinion in the record, including the assessment of Mr. Scarberry's treating physician, Dr. Sundaram, that establishes Mr. Scarberry has pneumoconiosis. Accordingly, in compliance with the *Compton* mandate, upon consideration of all the medical evidence in the record, particularly the preponderance of the radiographic findings and more probative medical opinion, I conclude Mr. Scarberry has proven the first requisite element of entitlement – he has pneumoconiosis in his lungs.

[46]Interestingly, the other doctor who was board certified in pulmonary disease, Dr. Spagnolo, as discussed above essentially hesitated to reach any conclusion because he only reviewed one chest x-ray interpretation.

Pneumoconiosis Arising out of Coal Mine Employment

Once a claimant has proven the existence of pneumoconiosis, 20 C.F.R. § 718.203 (a) requires that he also establish that his pneumoconiosis arose, at least in part, from his coal mine employment. If a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.[47] However, this presumption does not apply in Mr. Scarberry's case because he has established only six years of coal mine employment. Therefore, Mr. Scarberry has the burden of proof under 20 C.F.R. § 718.203 (c), which can be satisfied if "competent evidence establish[es] that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP*, 11 B.L.R. 1-110, 1-112 (1987). Mr. Scarberry must rely on medical evidence to show the relationship exists. *See Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986).

And so I return to the determination of relative probative weight of the physician opinions. First, since Dr. Hussain, Dr. Spagnolo, and Dr. Forehand did not render a definitive diagnosis of pneumoconiosis, their opinions have little probative value in determining whether Mr. Scarberry's pneumoconiosis arose out of coal mine employment.

Next, due to use of an incorrect employment history, Dr. Modi's determination that Mr. Scarberry's breathing symptoms were due to coal dust exposure also has diminished probative value. Upon his initial consideration of the case, Dr. Modi indicated that Mr. Scarberry had six years of coal mining employment and ten years of construction work; his last employment involved sand and gravel. At that point, Dr. Modi's summarization was fairly accurate. However, in the subsequent evaluation in which he specifically linked Mr. Scarberry's coal dust exposure and his pulmonary symptoms, Dr. Modi stated Mr. Scarberry had six years of coal mine employment and another fourteen years around mines. The additional fourteen years around mines is inaccurate, overstates Mr. Scarberry's exposure to coal dust, and diminishes the probative value of his opinion.[48]

Dr. Fritzhand's opinion on the source of Mr. Scarberry's pneumoconiosis also has diminished probative value due to his reliance on an incomplete work history. Although Dr. Fritzhand recognized that Mr. Scarberry was a non-smoker and had six years of coal mine employment, he did not address Mr. Scarberry's additional significant exposure to other environmental dust during his subsequent ten years of gravel pit employment. Since silica has been identified as a pulmonary risk factor by at least one other physician, Dr. Fritzhand's apparent failure to consider other irritants, such as gravel pit dust, rather than coal dust, as a source of Mr. Scarberry's pneumoconiosis undermines the probative value of his conclusion that Mr. Scarberry's pneumoconiosis is due to coal dust exposure.[49]

[47]20 C.F.R. § 718.203 (b).

[48]*See Barnes v. Director, OWCP*, 9 B.L.R. 1-71 (1995) (en banc on reconsideration).

[49]Dr. Modi's causation determination also suffers the same deficiency.

In probative medical opinions, Dr. Penman and Dr. Baxter accurately summarized and then considered Mr. Scarberry's six years of coal mine employment, ten to twelve years of gravel pit work, and lack of a cigarette smoking history. Both physicians believed Mr. Scarberry's employment exposed him to both coal dust and rock dust, which eventually caused pneumoconiosis.

Dr. Clarke relied on the same accurate work history and diagnosed anthrosilicosis, based on both dust hazards. Dr. Clarke additionally explained that at least one medical study established that coal dust exposure of as little as two years could lead to the development of pneumoconiosis in susceptible coal miners.

In a reasoned, well documented, and probative opinion, Dr. Sundaram recognized that Mr. Scarberry's work history of six years mining coal and ten years working in a gravel pit exposed him to two work-related dust hazards, coal dust and silica. He also emphasized the absence of cigarette smoke as a cause for Mr. Scarberry's obstructive impairment. Consequently, Dr. Sundaram determined Mr. Scarberry's pneumoconiosis and pulmonary impairment were due to both pulmonary irritants.

In conclusion, upon consideration of the medical opinion, the more probative assessments of Dr. Penman, Dr. Baxter, Dr. Clarke, and Dr. Sundaram establish that Mr. Scarberry's pneumoconiosis is related to his coal mine employment. As a result, Mr. Scarberry has proven the second requisite element of entitlement under 20 C.F.R. § 718.203 (c).

Total Disability

As previously discussed, to receive benefits under the Act, Mr. Scarberry must prove by the preponderance of the probative evidence that he has pneumoconiosis that arose out of his coal mine employment and that he is totally disabled due to coal workers' pneumoconiosis. Returning again to the third element of entitlement, in Mr. Scarberry's case, he may demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

By determining that Mr. Scarberry has established a change in condition based on total disability since Judge Neal's denial of his third modification request, I have already found Mr. Scarberry has proven this requisite element of entitlement. Up through Judge Neal's July 2001 denial of his modification request, the evidence in the record had been insufficient to establish total respiratory disability. However, in February 2002, an exercise arterial blood gas study demonstrated that Mr. Scarberry no longer had the respiratory capacity to place sufficient oxygen in his blood stream upon exercise. I found Dr. Hussain's conclusion that Mr. Scarberry suffered only a mild impairment, despite the qualifying blood gas study, not well reasoned. As a result, insufficient evidence exists in the record to rebut the finding that Mr. Scarberry has recently developed a total respiratory disability.[50] Accordingly, I find that Mr. Scarberry is totally disabled under the provisions of 20 C.F.R. § 718.204 (b) (2) (ii) and has established the third requisite element of entitlement.

[50]The finding of total disability is also somewhat supported by the well documented opinion of Dr. Sundaram, Mr. Scarberry's treating physician.

Total Disability Due to Coal Workers' Pneumoconiosis

Because Mr. Scarberry has established three of the four requisite elements for entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to coal workers' pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Under 20 C.F.R. § 718.204 (c) (1), absent regulatory presumptions in favor of a claimant,[51] the claimant must demonstrate that pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: a) had a material, adverse effect on his respiratory or pulmonary condition; or, b) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204 (c) (2) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report."

In terms of evidentiary weight, the assessments of the following physicians have little probative value because they: a) did not diagnose Mr. Scarberry with pneumoconiosis; b) inadequately assessed whether Mr. Scarberry's pneumoconiosis was related to coal mine employment; c) concluded he was not totally disabled; or, d) did not identify the cause of his total disability: Dr. Hussain, Dr. Spagnolo, Dr. Modi, Dr. Forehand, Dr. Baxter and Dr. Fritzhand.

The remaining three physicians, Dr. Sundaram, Dr. Penman, and Dr. Clarke, concluded Mr. Scarberry's totally disabling pulmonary impairment was significantly caused by coal workers' pneumoconiosis. Each doctor attributed his exposure to coal dust as a significant contributing factor in the development of pneumoconiosis; in turn, coal workers' pneumoconiosis played a major role in Mr. Scarberry's pulmonary impairment. In the absence of any probative contrary medical opinion or evidence, their professional agreement establishes that Mr. Scarberry is totally disabled due to coal workers' pneumoconiosis. Consequently, Mr. Scarberry has proved the final element of entitlement under 20 C.F.R. § 718.204 (c).

Augmentation

Benefits under the Act may be augmented for a person who meets the criteria of spouse under 20 C.F.R. § 725.204 and the dependency requirements of 20 C.F.R. § 725.205. Based on the parties stipulation of fact, I find that Mrs. Linda Scarberry is a qualified spouse and meets the regulatory requirements for spousal augmentation of Mr. Scarberry's black lung disability benefits.

Benefits under the Act may also be augmented for a dependent child for the duration of the dependency. A child under the age of 18, and over the age of 18 if a full time student, is considered to be dependent, 20 C.F.R. § 725.209.

[51]20 C.F.R. § 718.305 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption the claimant is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more of coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and, 20 C.F.R. § 718.306 (a presumption exists when a survivor files a claim prior to June 30, 1982).

During the hearing, neither party addressed whether Mr. Scarberry had any other dependents other than his wife. In his December 10, 2001 claim form (modification request), Mr. Scarberry also listed his son, Travis Shane Scarberry, as a dependent, reported his son's date of birth as "June 19, 1970;" and indicated that Travis was over 18 years old and a student. However, the birth certificate for Travis Shane Scarberry lists "June 19, 1987" as the date of birth (DX 1). Relying on the official birth certificate, I find Mr. Travis Scarberry, presently 17 years old, is a dependent son, such that additional augmentation of Mr. Scarberry's disability benefits for a dependent son is warranted at least through Mr. Travis Scarberry's eighteenth birthday on June 19, 2005.[52]

Date of Entitlement

Under 20 C.F.R. § 725.503 (d) (2), in the case of a coal miner who receives an award of disability benefits through a change of conditions under 20 C.F.R. § 725.310, benefits are payable beginning the month of onset of total disability provided no benefits are payable for any month prior to the effective date of the most recent denial of the claim by the administrative law judge. If the evidence does not establish the date of onset of total disability, then benefits are payable beginning the month the claimant requested modification.

Based on that guidance, three dates need to be established. First, in Mr. Scarberry's case, Judge Neal finally denied his third modification request in July 2001. Second, Mr. Scarberry filed his fourth modification request on December 10, 2001. Third, on February 13, 2002, based on a qualifying exercise arterial blood gas study, Mr. Scarberry demonstrated that he had become totally disabled.

Notably, the date of the arterial blood gas study only establishes that sometime between the close of the record before Judge Neal in October 2000 and the February 2002 test date, Mr. Scarberry became totally disabled.[53] Absent any other evidence, the record is insufficient to determine when the actual date of onset of total disability occurred between October 2000 and February 13, 2002. Accordingly, as directed by 20 C.F.R. §§ 725.503 (d) (2), I conclude that Mr. Newport is entitled to black lung disability benefits as of December 1, 2001 based on the date he filed his most recent modification request.

CONCLUSION

Through a February 2002 qualifying exercise arterial blood gas study, and in the absence of sufficient, probative contrary evidence, Mr. Scarberry has established that a change in his pulmonary condition has occurred since the denial of his third modification request by Judge Neal. As a result, his request for modification of the prior denial of his claim must be approved.

[52]If Mr. Travis Scarberry continues to go school past his eighteenth birthday, then Mr. Scarberry may seek additional augmentation beyond June 19, 2005 under 20 C.F.R. § 725.209 (b) (1) through the modification process.

[53]*See Tobrey v. Director, OWC*P, 7 B.L.R. 1-407, 1-409 (1985) (at best, the date of examination indicates that some time prior to the examination, total disability onset occurred).

Subsequently, upon consideration of the entire record, I have determined that Mr. Scarberry has pneumoconiosis due in part to his coal mine employment. Mr. Scarberry is also totally disabled due to coal workers' pneumoconiosis. Accordingly, his claim for black lung disability benefits under the Act must be approved. In accordance with 20 C.F.R. § 725.503 (d), the date of entitlement is December 1, 2001. Mr. Scarberry's benefits will be augmented for his two dependents, Mrs. Linda Scarberry and Mr. Travis Shane Scarberry.

ATTORNEY FEES

Counsel for the Claimant has thirty days from receipt of this decision to submit an additional application for attorney fees related to this case in accordance with 20 C.F.R. § 725.365 and 725.366. With the application, counsel must attach a document showing service of the fee application upon all parties, including the Claimant. The other parties have fifteen days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with the claim.

ORDER

The modification request by MR. LIGE M. SCARBERRY is **APPROVED.** His claim for black lung disability benefits under the Act is **GRANTED**. Benefits shall commence December 1, 2001, augmented for his spouse, Mrs. Linda Scarberry, from December 1, 2001 and continuing, and for his dependent son, Mr. Travis Shane Scarberry, from December 1, 2001 through at least June 19, 2005.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: October 22, 2004
Washington, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481 (2001), any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 (2001) and § 725.479 (2001). A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1

American Board of Medical Specialties
Certification:

Raghu R. Sundaram, MD

Certified by the American Board of Internal Medicine in:

Internal Medicine

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